Informed Consent to Breech Birth

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Structure

1. Importance of working together for breech
2. Duty to provide information
3. Prohibition on providing care without consent
4. Coerced consent
5. The boundaries of consent

Women's Experiences

- Women in the *Breech Birth Australia & New Zealand* Facebook group were asked:

  "What information were you provided about your birth options and the associated risks …. What would you have liked to be told about (by your maternity care provider)?"

- Quotes are presented as anecdotes only.

Working together

Code of Health & Disability Services Consumers' Rights:

4(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services

Information

"The [obstetrician] for my first breech pregnancy told me that no-one offered VBB or ECV… because it was not safe for the baby or the mother ... He didn't go into any detail about the risks..." (Adelaide)

When?

- Women need time to reflect on decisions and ask questions
- The availability of a breech-experienced care provider might influence a woman's choice to undergo ECV
- After a failed ECV is too late to first discuss birth options
- Balanced against unnecessary stress by discussing options that may become irrelevant?

Duty to provide information

Code of Rights, Right 6(2)

Before making a choice or giving consent, every consumer as the right to the information that a reasonable consumer in that consumer's circumstances, needs to make an informed choice or give informed consent.

What?

Includes the right to be told about:

- all relevant options, including options not offered by the health service
- all relevant risks, including risks of CS, risks to future pregnancies, chance of recurrent breech presentation and effect of choices on this
- the evidence base of information (if any)
- what most providers would recommend
- skills and experience of available providers
- how to get a second opinion

and the right to express a preference for a breech-experienced care provider (Right 7(8))

VBAC next time?

“My daughter was footling breech. After two failed ECVs the ob played the dead baby card and pretty much said an ECS was the best option (when presented with the stats, I agree) BUT what annoys me is he never went through the risks of a CS in terms of future pregnancies and the shitfight I will most likely have with a VBAC in a hospital. He just said "don’t worry, you can have a VBAC next time"...”

Many women experience difficulty finding supportive care for a VBAC and this is a relevant factor.

Vlemmix et al, AJOG, 2013

"Women who underwent an elective CS in their first pregnancy had an increased risk of uterine rupture (0.7 vs. 2.2‰, OR 3.8, 95%CI 1.4-10.3)and HPP (42.1 vs. 57.1‰, OR 1.4, 95%CI 1.2-1.6).

The children born from these women had an increased risk of Apgar score <7 (11.4 vs. 13.8‰, OR 1.4, 95%CI 1.1-1.9).

Neonatal mortality was twice as high compared to the planned vaginal delivery group (1.3 vs. 2.5‰, OR 2.1, 95%CI 0.96-4.5) although this was not statistical significant (p0.06)"

Term Breech Trial (TBT)

- Women should be presented with information relevant to the woman's individual circumstances
- If the TBT is discussed (depends on level of information woman wishes to hear), then this should be balanced with:
  - Studies showing *little or no difference* in long-term outcomes (eg 2015 Cochrane Review)
  - Evidence from population-based research, showing *less difference* than the TBT (eg Reitburg 2005, Vlemmix 2014)
  - Relevant cohort studies showing *no difference in outcomes* in some circumstances (eg Goffinet 2006, Borbolla Foster 2014)
- Women need to be told how to assess this information

Individualised Advice

"I believe if I had not known to ask I would not have been give the option... I felt that the [obstetricians] gave a lot of statistics about the 'average' response but not really focusing on me and my pregnancy." (Perth)

Provider's views?

- Provider's *clinical assessment* and any personal or institutional constraints **are relevant** in terms of providing recommendations

- Provider's *personal views* on birthing are NOT a reason to require a woman to undergo surgery – refer

Risks

"social and legal developments point away from a model of the relationship between the doctor and the patient based upon medical paternalism … [and] instead … treats them … as adults who are capable of understanding that their medical treatment is uncertain of success and may involve risks, accepting responsibility of taking risks affecting their own lives, and living with the consequences of their choices"

(*Montgomery v Lanarkshire Health Board*, 2015)

Presenting Risks

- NICE Guideline CG138 'Patient Experience in Adult NHS Services' 1.5.24:
  - Personalise risks to the individual patient – rather than presenting population-based information
  - Present risks in absolute rather than relative terms (eg 'the risk increases from 1 in 1000 to 2 in 1000' rather than 'the risk doubles')
  - Use natural frequencies (10 in 100 rather than 10%)
  - Be consistent in the use of data – use the same denominator
  - Use both positive and negative framing (eg treatment will be successful for 97/100 patients and unsuccessful for 3/100 patients)
  - Consider pictorial formats rather than numbers
  - Most risks associated with VBB should be described as 'uncommon'

Consent to breech birth?

- Although the duty to provide information applies to all births, consent is not required for allowing a natural process to proceed

Valid Consent

1. The woman has **capacity** to make the decision in question.
   - Irrationality or unreasonableness do not amount to incapacity.

2. The decision is made **freely** and voluntarily.

3. The consent **covers the act** to be performed.
   - Consent to vaginal examination does not cover stretch & sweep.

Refusal of consent

- A competent woman **may refuse** an ECV, CS, information, consultation or referral
- A provider **cannot be compelled** to provide care they believe is clinically inappropriate but **cannot require** a woman to undergo surgery

Right to refuse medical treatment

- Common law tort of battery – right to sue for nominal damages
- HDC Code of Rights
- New Zealand Bill of Rights Act 1990, s11 (applies to public authorities only)
- Emergency exception rare (woman must be incompetent)

Consent in pregnancy

"A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth … alongside the medical evaluation of the risks to herself and her baby … The medical profession must respect her choice, unless she lacks the legal capacity to decide."

Montgomery v Lanarchshire Health Board (para 115)

Coercion for breech

- Not "offering" any alternative to caesarean
- Hospital policies which make no allowance for refusal of caesarean
- Misleading information about risks
- Threatening to withdraw care for non-compliance

Coercion

“The hospital midwives had to transfer me to the OBs who threatened to call child protective services and get a court order to perform a cesarean and then remove my child from my and my husband's care if I didn't "consent" to an elective cesarean...” (USA)

If things go wrong

- Consent provides an answer to allegations that a provider should have provided different care
- Duty to provide reasonable care in the circumstances (cf to provide 'best practice' care against the wishes of the patient)
- "Boundaries of Consent"

Summary

- The law supports the right of the woman to make an informed choice
- The role of the provider is to support and advise her
- Providers have duties to provide full and unbiased information about risks and benefits of ECV, VBB or CS
- Women have rights to:
  - make an informed choice
  - give or refuse consent
  - co-operation amongst providers
- Providers have no duty to provide care they believe is clinically inappropriate BUT this does not enable them to require a woman to undergo surgery